

<i>SERFF Tracking Number:</i>	<i>RENA-126574818</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Renaissance Life & Health Insurance Company</i>	<i>State Tracking Number:</i>	<i>45522</i>
	<i>of America</i>		
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H10I Individual Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10I.000 Health - Dental</i>
<i>Product Name:</i>	<i>Ren/Ren v3 Application</i>		
<i>Project Name/Number:</i>	<i>Ren/Ren v3 Application/Ren/Ren v3 Application</i>		

Filing at a Glance

Company: Renaissance Life & Health Insurance Company of America

Product Name: Ren/Ren v3 Application

SERFF Tr Num: RENA-126574818 State: Arkansas

TOI: H10I Individual Health - Dental

SERFF Status: Closed-Approved-
Closed

Sub-TOI: H10I.000 Health - Dental

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Denise Chadwell, Errick
Phillips, Todd Svanda

Disposition Date: 04/28/2010

Date Submitted: 04/27/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Ren/Ren v3 Application

Status of Filing in Domicile: Pending

Project Number: Ren/Ren v3 Application

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Filed in our
domiciliary state of Indiana on April 8th, 2010.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 04/28/2010

Explanation for Other Group Market Type:

State Status Changed: 04/28/2010

Deemer Date:

Created By: Errick Phillips

Submitted By: Errick Phillips

Corresponding Filing Tracking Number:

Filing Description:

April 27, 2010

Arkansas Insurance Department

1200 West 3rd Street

Little Rock, AR 72201-1904

SERFF Tracking Number: RENA-126574818 State: Arkansas
Filing Company: Renaissance Life & Health Insurance Company State Tracking Number: 45522
of America
Company Tracking Number:
TOI: H10I Individual Health - Dental Sub-TOI: H10I.000 Health - Dental
Product Name: Ren/Ren v3 Application
Project Name/Number: Ren/Ren v3 Application/Ren/Ren v3 Application

Re: Renaissance Life & Health Insurance Company of America (N.A.I.C. No. 61700)
FEIN# 47-0397286, Group No. 0477
Individual Dental Product – Application Filing
Form Number – INVD-103A v3
SERFF Tracking Number – RENA-126574818

Dear Sir or Madam:

Enclosed you will find an application form to be filed with your department. This form will be used in conjunction with policy form number INVD-100A-AR v2, approved by your department on March 27, 2009 under SERFF Tracking number RENA-126015467. This form replaces form INVD-103A v2, also approved by your department on March 27, 2009, in filing number RENA-126015467. Enclosed are the following documents:

1. Form INVD-103A v3, the individual application/enrollment form; and
2. Any appropriate transmittal forms and/or filing fees.

This form will be used via mail, in person with agents, and through electronic means. This form will be used in conjunction with our approved individual dental product, policy form listed above.

Should you have any questions or require any additional information, please contact me directly at (517) 347-5352, by e-mail at ephillips@renaissancefamily.com, or via SERFF. Thank you for your assistance.

Sincerely,

Errick Phillips
Regulatory Specialist
Renaissance Life & Health Insurance Company of America

Enclosures

Company and Contact

Filing Contact Information

Errick Phillips, Regulatory Specialist	ephillips@renaissancefamily.com
P.O. Box 30381	517-347-5352 [Phone]
Lansing, MI 48909-7881	517-347-5433 [FAX]

Filing Company Information

<i>SERFF Tracking Number:</i>	<i>RENA-126574818</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Renaissance Life & Health Insurance Company</i>	<i>State Tracking Number:</i>	<i>45522</i>
	<i>of America</i>		
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H10I Individual Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10I.000 Health - Dental</i>
<i>Product Name:</i>	<i>Ren/Ren v3 Application</i>		
<i>Project Name/Number:</i>	<i>Ren/Ren v3 Application/Ren/Ren v3 Application</i>		
Renaissance Life & Health Insurance Company CoCode: 61700		State of Domicile: Indiana	
of America			
P.O. Box 30381	Group Code: 477	Company Type: Life & Health	
Lansing, MI 48909-7881	Group Name:	State ID Number:	
(800) 745-7509 ext. [Phone]	FEIN Number: 47-0397286		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	1 filing @ \$50 per filing.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Renaissance Life & Health Insurance Company of America	\$50.00	04/27/2010	35991843

SERFF Tracking Number: RENA-126574818 State: Arkansas
Filing Company: Renaissance Life & Health Insurance Company State Tracking Number: 45522
of America
Company Tracking Number:
TOI: H10I Individual Health - Dental Sub-TOI: H10I.000 Health - Dental
Product Name: Ren/Ren v3 Application
Project Name/Number: Ren/Ren v3 Application/Ren/Ren v3 Application

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/28/2010	04/28/2010

State: *Arkansas*

Filing Company: Renaissance Life & Health Insurance Company of America State Tracking Number: 45522

Company Tracking Number:

TOI: H10I Individual Health - Dental

Sub-TOI: *H10I.000 Health - Dental*

Product Name: Ren/Ren v3 Application

Project Name/Number: Ren/Ren v3 Application/Ren/Ren v3 Application

Disposition

Disposition Date: 04/28/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: RENA-126574818 State: Arkansas
 Filing Company: Renaissance Life & Health Insurance Company State Tracking Number: 45522
 of America

Company Tracking Number:

TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental

Product Name: Ren/Ren v3 Application

Project Name/Number: Ren/Ren v3 Application/Ren/Ren v3 Application

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Redline	Approved-Closed	Yes
Form	Individual Dental Application/Enrollment	Approved-Closed	Yes

SERFF Tracking Number: RENA-126574818 State: Arkansas

Filing Company: Renaissance Life & Health Insurance Company of America State Tracking Number: 45522

Company Tracking Number:

TOI: H10I Individual Health - Dental Sub-TOI: H10I.000 Health - Dental

Product Name: Ren/Ren v3 Application

Project Name/Number: Ren/Ren v3 Application/Ren/Ren v3 Application

Form Schedule

Lead Form Number: INVD-103A v3

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/28/2010	INVD-103A v3	Application/ Individual Enrollment Form	Dental Application/Enrollment	Initial		46.700	INVD-103A v3.pdf

Individual Dental Enrollment/Update

Enroll online now at www.aaaaaaaaaaaaa.com or complete this form and mail to:

[Renaissance Life & Health Insurance Company of America
6651 Paysphere Circle
Chicago, IL 60671]

If you have any questions about filling out this form, please contact our Customer Service department at [(888) 791-5995].

- ☐ New Enrollment—Check for first-time enrollment for yourself or your spouse.
- ☐ Change/Correction to Information—Check if any changes are being submitted on this form.
- ☐ Termination of Benefits—Check only if you are terminating coverage for yourself or your spouse.

[Region X – xx, xx, xx, xx, xx, xx]

Will this policy replace or change any existing policy of dental insurance? ☐ Yes ☐ No

If yes, please describe: _____

Company Name _____ Policy Number _____

(This section must be completed for us to process your enrollment or update your records. Please print clearly or type.)

Example A B C D E F 1 2 3 4 5 6					
Enrollee Name (First)		(M.I.)	(Last)		
<input type="text"/>		<input type="text"/>	<input type="text"/>		
Birth Date	Sex	Enrollee Social Security Number			
<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>			
Street Address					
<input type="text"/>					
City		State	ZIP Code		
<input type="text"/>		<input type="text"/>	<input type="text"/> - <input type="text"/>		
E-mail Address (Optional)			Telephone Number		
<input type="text"/>			<input type="text"/> - <input type="text"/> - <input type="text"/>		
Coverage Effective Date					
<input type="text"/> - <input type="text"/> - <input type="text"/> [(Access Code: Internal Use Only)]					
(date coverage takes effect for you and/or your spouse)					

Spouse Information (Please complete this section if you are enrolling your spouse for the first time or if you have checked Change/Correction above and are changing information about your spouse that was previously submitted. You must include your spouse's first and last names.)

Spouse Name (First)		(M.I.)	(Last)		
<input type="text"/>		<input type="text"/>	<input type="text"/>		
Birth Date	Sex	Social Security Number			
<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>			

Dependent Child Information

#1- Dependent Child Name (First)		(M.I.)	(Last)		
<input type="text"/>		<input type="text"/>	<input type="text"/>		
Birth Date	Sex	Social Security Number			
<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>			

#2- Dependent Child Name (First)

(M.I.) (Last)

Birth Date

Sex

Social Security Number

Male ☐Female ☐

#3- Dependent Child Name (First)

(M.I.) (Last)

Birth Date

Sex

Social Security Number

Male ☐Female ☐

#4- Dependent Child Name (First)

(M.I.) (Last)

Birth Date

Sex

Social Security Number

Male ☐Female ☐

#5- Dependent Child Name (First)

(M.I.) (Last)

Birth Date

Sex

Social Security Number

Male ☐Female ☐

Payment Information (The amount payable for coverage varies based on the coverage option selected, the number of people enrolled, and the payment frequency. You may choose only one option, regardless of the number of people enrolling):

Rates:

Single

Two Person

[Family Rate

Monthly/Annual

Monthly/Annual

Monthly/Annual

☐ [Plan I]

[\$xx.xx/\$xxx.xx]

[\$xx.xx/\$xxx.xx]

[\$xxx.xx/\$x,xxx.xx]

☐ [Plan II]

[\$xx.xx/\$xxx.xx]

[\$xx.xx/\$xxx.xx]

[\$xxx.xx/\$x,xxx.xx]

Payment Frequency:☐ Annual (If you are paying by check, you **must** choose this option and pay the amount due in full)☐ Monthly (If you are paying by credit card or automatic withdrawal, you may choose this option)**Choose the payment method:**☐ Check payable to RLHICA (you may pay by check only if you choose an annual payment)☐ MasterCard☐ VISA☐ American Express☐ Discover]

Card Number

Exp. Date

Cardholder Name (as it appears on card)

Credit Card Billing Address (if different from mailing address)

Street Address

City

State

ZIP Code

I hereby authorize RLHICA, subsidiaries, and affiliates to charge my credit card for premiums due. This authorization will remain in effect until RLHICA has received written notice from me of its termination. If the billing amount changes, RLHICA will provide a minimum of 10 days' notice to the cardholder.

Cardholder's Signature _____ Date _____

☐ Automatic withdrawal from bank account

11:01 01234561	1987654321011" 1234
Routing number	Account number

[illegible]

Account Number

☐ Checking Account

--	--	--	--	--	--	--	--	--

[illegible]

☐ Savings Account

I hereby authorize RLHICA, subsidiaries, and affiliates to initiate automatic withdrawals (ACH) from the account indicated above. This authorization will remain in effect until RLHICA has received written notification from me of its termination and/or my payment obligation has been satisfied. I understand that I am responsible for any fees incurred due to my payment being rejected for processing by my bank.

Accountholder's Signature _____ Date _____

Validation Question (choose ONE and answer below):

☐ Mother's maiden name (last name only) OR ☐ City in which you were born OR ☐ Name of first pet

[illegible]

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. (Please see the following page for state-specific variations of this fraud notice.)

Applicant's Signature _____ Date _____

Please mail enrollment form (and check, if applicable) to:

**[Renaissance Life & Health Insurance Company of America
6651 Paysphere Circle
Chicago, IL 60671]**

Fraud Warning Notices: (If the proposed insured or owner lives in a state where one of the fraud warning notices apply, please review the notice that applies to your state.)

Arkansas/Louisiana/New/Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a certificate holder or claimant for the purpose of defrauding or attempting to defraud the policy or certificate holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department regulatory agencies.

DC: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky/Ohio: I understand that any person who, with intent to defraud, or knowing that he or she is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement is guilty of insurance fraud.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefit.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto omits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee/Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Required California Notice: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

_____(Owner's Initials)

SERFF Tracking Number: RENA-126574818 State: Arkansas
 Filing Company: Renaissance Life & Health Insurance Company of America State Tracking Number: 45522
 Company Tracking Number:
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: Ren/Ren v3 Application
 Project Name/Number: Ren/Ren v3 Application/Ren/Ren v3 Application

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	04/28/2010
Comments:		
Attachment: Readability Certification - Signed.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	04/28/2010
Comments: We are submitting an application form for approval.		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification	Approved-Closed	04/28/2010
Bypass Reason: This is an application-only filing that does not include, or impact, rates.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage	Approved-Closed	04/28/2010
Comments: Attached is the current approved outline of coverage used with the policy corresponding to this application form.		
Attachment: INVD-AR-041A.pdf		

	Item Status:	Status Date:
Satisfied - Item: Redline	Approved-Closed	04/28/2010
Comments:		

SERFF Tracking Number: RENA-126574818 State: Arkansas
Filing Company: Renaissance Life & Health Insurance Company State Tracking Number: 45522
of America
Company Tracking Number:
TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
Product Name: Ren/Ren v3 Application
Project Name/Number: Ren/Ren v3 Application/Ren/Ren v3 Application

Attachment:

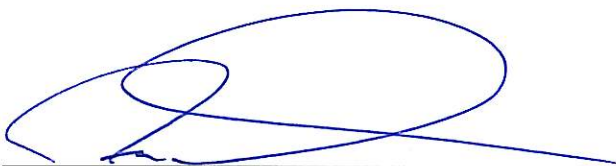
INVD-103A v3 Redline.pdf

READABILITY CERTIFICATION

Company Name: Renaissance Life & Health Insurance Company of America

I hereby certify, that the form(s) listed below have the following readability score(s) as calculated by the Flesch Reading Ease Test.

Form Number	Score
INVD-103A v3	46.7



Jonathan S. Groat
Vice President and General Counsel

April 22, 2010

Date

**Renaissance Life & Health Insurance Company™
of America**

**P.O. Box 738
Greenwood, Indiana 46142**

**OUTLINE OF COVERAGE
LIMITED HEALTH BENEFIT COVERAGE
INDIVIDUAL DENTAL INSURANCE
Policy Form INV-D-100A-AR**

Read your Policy carefully — This outline provides a very brief description of the important features of your Policy. This is not the insurance contract and only the actual Policy provision will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

COVERAGE

Unless otherwise specified in the Summary of Dental Plan Benefits, Benefits may be divided into the following classes.

Please see the Summary of Dental Plan Benefits for the classification of Benefits, exclusions and limitations applicable under your Policy.

1. **Class I Benefits**
 - a. Diagnostic and Preventive Services
2. **Class II Benefits**
 - a. Emergency Palliative Treatment.
 - b. Radiographs (x-rays)/Diagnostic Imaging.
 - c. X-rays as required for routine care or as necessary for the diagnosis of a specific condition.
 - d. Minor Restorative Services.
 - e. Simple Extractions.
 - f. Sealants.
 - g. Periodontal Maintenance Following Therapy.
3. **Other Class II Services**
 - a. After hours visits, not to exceed once per Benefit Year.
 - b. Benefits for consultations (includes evaluation) by a dentist other than the practitioner providing treatment are payable once per Benefit Year.
4. **Class III Benefits**

- a. Oral Surgery Services.
 - b. Endodontic Services
 - c. Periodontic Services.
 - d. Major Restorative.
 - e. Prosthodontic Services.
 - f. Relines and Repairs.
5. **Other Class III Services**
- a. Benefits for an occlusal guard are payable only once in a lifetime.
 - b. Benefits for limited occlusal adjustments are payable once in a five-year period.
 - c. Office visits during regularly scheduled hours are payable once per Benefit Year.
6. **Class IV Benefits**
- a. Orthodontic Services.

EXCLUSIONS AND LIMITATIONS

- 1. Services for injuries or conditions paid pursuant to Workers' Compensation or Employer's Liability laws. Benefits or services that are received from any government agency, political subdivision, community agency, foundation, or similar entity.
NOTE: This exclusion does not apply to any programs provided under Title XIX Social Security Act, that is, Medicaid.
- 2. Services or appliances started prior to the date the person became covered under the Policy-
- 3. Charges for failure to keep a scheduled visit with the Dentist.
- 4. Charges for completion of forms or submission of claims.
- 5. Services for which no valid dental need can be demonstrated, that are specialized techniques, or that are investigational in nature as determined by the standards of generally accepted dental practice.
- 6. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the scope of his or her license.
- 7. Services or supplies for which no charge is made, for which the patient is not legally obligated to pay or for which no charge would be made in the absence of RLHICA coverage.
- 8. Services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.

9. Services that are generally covered under a hospital, surgical/medical, or prescription drug program.
10. Services that are not within the classes of Benefits that have been selected and shown on the Summary of Dental Plan Benefits.

Limitations:

1. RLHICA's obligation for payment of Benefits ends on the date that the Policy terminates.
2. When services in progress are interrupted and completed later by another Dentist, RLHICA will review the claim to determine the amount of payment, if any, to each Dentist.
3. Care terminated due to the death of an Insured or Eligible Dependent will be paid to the limit of RLHICA's liability for the services completed or in progress.
4. The maximum Benefit payable in any one Benefit Year will be limited to the amount specified in the Summary of Dental Plan Benefits.
5. If a plan Deductible amount is specified in the Summary of Dental Plan Benefits, RLHICA will not be obligated to pay for, in whole or in part, any services until the Deductible amount is met.

RENEWABILITY

Conditionally Renewable-Premium May Change: The Insured may keep the Policy in force by timely payment of the premiums. However, we may refuse renewal due to:

- A. non-payment of premium, subject to the Grace Period provision;
- B. fraud or material misrepresentation made by or with the knowledge of the Insured or an Eligible Dependent applying for this coverage or filing a claim for benefits;
- C. the Insured engaging in intentional and abusive noncompliance with material provisions of the Policy;
- D. the company ceasing to renew all policies issued to on this form to residents of the state where you live.

We may refuse renewal for reasons (A) – (D) above as of any premium due date.

At least 30 days notice of any non-renewal action permitted by this clause will be mailed to the Insured at your last address as shown in our records. If we fail to provide 30 days notice of our intent to terminate coverage, your coverage will remain in effect until 30 days after notice is given or until the effective date of replacement coverage, whichever occurs first. However, no benefits will be paid for expenses incurred during any period of time for which premium has not been paid.

PREMIUM PAYMENT

Each premium is to be paid on or before its due date. Premium may be paid for a 12 month time period or monthly if paid by credit card or direct debit from your checking account.

From time to time, RLHICA may change the rate tables used for this policy form. Each premium will be based on the rate table in effect on that premium's due date. The policy plan, age and sex of Insureds, time the policy has been in force, and place of residence on the premium due date are factors used in determining premium rates. RLHICA will make no change in your premium

solely because of claims made under this Policy. At least 60 days notice of any plan to change rates as permitted by this clause will be mailed to the Insured at your last address as shown in our records.

Individual Dental Enrollment/Update

Enroll online now at www.xxxxxxxxxxxxxx.com or complete this form and mail to:

[xxxxx xxxxxx xxxx xx xxxxxxxx. xxx.
xxxxx xxxxxxxxxxx xxxxxx xxxxx
xxxxxxx, xx xxxxx]

Please fill out this form if you are enrolling for individual dental coverage for the first time or if you are changing information from an earlier enrollment. If you have any questions about filling out this form, please contact our Customer Service department at [(888) 791-5995].

- ☐ New Enrollment—Check for first-time enrollment for yourself or your spouse.
☐ Change/Correction to Information—Check if any changes are being submitted on this form.
☐ Termination of Benefits—Check only if you are terminating coverage for yourself or your spouse.

[Region X – xx, xx, xx, xx, xx, xx]

Will this policy replace or change any existing policy of **health-dental** insurance? ☐ Yes ☐ No
If yes, please describe: _____
Company Name _____ Policy Number _____

(This section must be completed for us to process your enrollment or update your records. Please print clearly or type.)

Enrollee Name (First)		(M.I.)	(Last)
<input type="text"/>		<input type="text"/>	<input type="text"/>
Birth Date	Sex	Enrollee Social Security Number	
<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	
Street Address			
<input type="text"/>			
City	State	ZIP Code	
<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/>	
E-mail Address (Optional)		Telephone Number	
<input type="text"/>		<input type="text"/> - <input type="text"/> - <input type="text"/>	
Coverage Effective Date			
<input type="text"/> - <input type="text"/> - <input type="text"/> [(Access Code: Internal Use Only)]			
(date coverage takes effect for you and/or your spouse)			

Spouse Information (Please complete this section if you are enrolling your spouse for the first time or if you have checked Change/Correction above and are changing information about your spouse that was previously submitted. You must include your spouse's first and last names.)

Spouse Name (First)		(M.I.)	(Last)
<input type="text"/>		<input type="text"/>	<input type="text"/>
Birth Date	Sex	Social Security Number	
<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	

Dependent Name	Sex Male/Female	Birth Date	Social Security Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

#1- Dependent Child Name																(First)			(M.I.)	(Last)												
																<input type="checkbox"/>																
Birth Date				Sex				Social Security Number																								
MM		DD		YY		<u>Male</u> <input type="checkbox"/> <u>Female</u> <input type="checkbox"/>		SSN = MM DD YY																								
#2- Dependent Child Name																(First)			(M.I.)	(Last)												
																<input type="checkbox"/>																
Birth Date				Sex				Social Security Number																								
MM		DD		YY		<u>Male</u> <input type="checkbox"/> <u>Female</u> <input type="checkbox"/>		SSN = MM DD YY																								
#3- Dependent Child Name																(First)			(M.I.)	(Last)												
																<input type="checkbox"/>																
Birth Date				Sex				Social Security Number																								
MM		DD		YY		<u>Male</u> <input type="checkbox"/> <u>Female</u> <input type="checkbox"/>		SSN = MM DD YY																								
#4- Dependent Child Name																(First)			(M.I.)	(Last)												
																<input type="checkbox"/>																
Birth Date				Sex				Social Security Number																								
MM		DD		YY		<u>Male</u> <input type="checkbox"/> <u>Female</u> <input type="checkbox"/>		SSN = MM DD YY																								
#5- Dependent Child Name																(First)			(M.I.)	(Last)												
																<input type="checkbox"/>																
Birth Date				Sex				Social Security Number																								
MM		DD		YY		<u>Male</u> <input type="checkbox"/> <u>Female</u> <input type="checkbox"/>		SSN = MM DD YY																								

Rates:	Single Monthly/Annual	Two Person Monthly/Annual	[Family Rate Monthly/Annual
an.1		[\$xx.xx/\$xxx.xx]	[\$xx.xx/\$xxx.xx]
\$xxx.xx/\$x,xxx.xx			

Payment Frequency:

☐ Annual (If you are paying by check, you **must** choose this option and pay the amount due in full)

☐ Monthly (If you are paying by credit card or automatic withdrawal, you may choose this option)

☒ MasterCard ☐ VISA ☐ American Express ☐ Discover]

Card Number

--	--	--	--	--	--	--	--	--	--

 Exp. Date

		-					
--	--	---	--	--	--	--	--

[illegible]

Credit Card Billing Address (if different from mailing address)

Formatted: Font: (Default) Arial, 10 pt

Street Address

City

State

ZIPCode

I hereby authorize RLHICA, subsidiaries, and affiliates to charge my credit card for premiums due. This authorization will remain in effect until RLHICA has received written notice from me of its termination. If the billing amount changes, RLHICA will provide a minimum of 10 days' notice to the cardholder.

Cardholder's Signature

Date

☐ Automatic withdrawal from bank account

John J. Doe1-19831234

Jane K. Doe

4321 Main St.

Anytown, MI 45678

Pay to the order of\$

XYZ BankDOLLARS

EdrMP

1:01 01234561987654321011" 1234

Routing numberAccount number

Bank Name

Routing Number

Account Number

☐ Checking Account

☐ Savings Account

I hereby authorize RLHICA, subsidiaries, and affiliates to initiate automatic withdrawals (ACH) from the account indicated above. This authorization will remain in effect until RLHICA has received written notification from me of its termination and/or my payment obligation has been satisfied. I understand that I am responsible for any fees incurred due to my payment being rejected for processing by my bank.

Accountholder's Signature

Date

Validation Question (choose ONE and answer below):

☐ Mother's maiden name (last name only)

OR

☐ City in which you were born

OR

☐ Name of first pet

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. (Please see the following page for state-specific variations of this fraud notice.)

Applicant's Signature

Date

Please mail enrollment form (and check, if applicable) to:

Renaissance Life & Health Insurance Company of America

6651 Paysphere Circle

Chicago, IL 60671

Formatted: Font: Bold

Formatted: Font: Bold

Fraud Warning Notices: (If the proposed insured or owner lives in a state where one of the fraud warning notices apply, please review the notice that applies to your state.)

Arkansas/Louisiana/New/Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a certificate holder or claimant for the purpose of defrauding or attempting to defraud the policy or certificate holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department regulatory agencies.

DC: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky/Ohio: I understand that any person who, with intent to defraud, or knowing that he or she is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement is guilty of insurance fraud.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefit.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto omits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee/Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Required California Notice: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

_____(Owner's Initials)